Washington State Department of Social & Health Services

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

DDD MORTALITY REVIEW

PART 2. CASE RESOURCE MANAGER REPORT

NAME OF PERSON COMPLETING FORM (PRINT)	
POSITION/TITLE	
DATE COMPLETED	TELEPHONE NUMBER

Complete upon receipt of Part 1. Provider Report and forward both parts to the Regional Quality Assurance Program Manager within **14** calendar days of receipt of the Provider Report.

This form should be completed based on all records available for review concerning this death.

I. GENERAL INFORMATION

1. DECEASED'S LEGAL NAME	2. CLIENT ID NUMBER	3. REGION	4. NAME OF CASE RESOURCE MANAGER

5. APPARENT CAUSE OF DEATH (IF DIFFERENT THAN DESCRIBED IN PART 1. PROVIDER REPORT), STATE SOURCE OF INFORMATION

6. DUE TO OR AS A CONSEQUENCE OF (IF DIFFERENT THAN DESCRIBED IN PART 1. PROVIDER REPORT), STATE SOURCE OF INFORMATION

7. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE APPARENT CAUSE LISTED ABOVE (IF DIFFERENT THAN DESCRIBED IN PART 1. PROVIDER REPORT)), STATE SOURCE OF INFORMATION

	YES	NO
8. Was the case referred to the medical examiner or coroner?	☐	☐
9. Was an autopsy conducted?	☐	☐
10. In your opinion was the death in any way unusual or unexplained? If yes, explain in Section IV.	☐	☐
If yes, total number of incident reports referred to CPS/APS/RCS regarding the deceased within last 24 months: _____		
11. Total number of investigations conducted by CPS/APS/RCS regarding the deceased within last 24 months: _____		
12. Is CPS/APS/RCS investigating the death? If yes, explain in Section III	☐	☐
13. Is law enforcement investigating the death? If yes, explain in Section III	☐	☐
14. Was the deceased on a Medicaid Waiver?	☐	☐
15. Was deceased a Community Protection client?	☐	☐
16. Was deceased a class action member (e.g., Allen, Marr, other)? If yes, specify: _____	☐	☐

17. WAS A TOXICOLOGY SCREEN CONDUCTED ON THE DECEASED?

☐ Yes; specify type and results below, if known (check all that apply). State source of information: _____

☐ Blood	☐ Positive (explain in Section V)	☐ Negative	☐ Inconclusive	☐ Pending
☐ Urine	☐ Positive (explain in Section V)	☐ Negative	☐ Inconclusive	☐ Pending
☐ Other _____	☐ Positive (explain in Section V)	☐ Negative	☐ Inconclusive	☐ Pending

☐ No

☐ Unknown at this time

18. WERE X-RAYS OF THE DECEASED TAKEN JUST PRIOR TO OR AFTER DEATH?

☐ Yes; state source of information: _____ ☐ No ☐ Unknown

- ☐ Evidence of abuse/neglect (explain in Section III)
- ☐ No evidence of abuse/neglect
- ☐ Unknown if evidence of abuse/neglect

DDD MORTALITY REVIEW, PART 2. CASE RESOURCE MANAGER REPORT

I. GENERAL INFORMATION (CONTINUED)

19. WAS A VIOLENT ACT ASSOCIATED WITH THE PERSON'S DEATH?

☐ Yes (specify) _____
☐ No

20. Was an alleged perpetrator identified by law enforcement in this death? .... ☐ Yes ☐ No
21. Were charges filed against an alleged perpetrator in this death? ..... ☐ Yes ☐ No ☐ Unknown
    If yes, specify _____
22. Does the alleged perpetrator care for other vulnerable persons? ..... ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
23. Was alleged perpetrator living with the deceased at time of deceased's death? ..... ☐ Yes ☐ No ☐ Unknown ☐ Not applicable

II. MENTAL HEALTH

	YES	NO	UNKNOWN
1. Was deceased known to have a diagnosed mental illness?	☐	☐	☐
If yes, specify: _____			
2. Had deceased ever received mental health treatment?	☐	☐	☐

If death was an apparent suicide, answer the questions below. Explain all YES answers in Section III below.

3. Was deceased known to have ever attempted suicide?	☐	☐	☐
4. Was deceased known to have recently spoken of suicidal thoughts?	☐	☐	☐
5. Was deceased known to have experienced a life crisis just prior to death?	☐	☐	☐
7. Was deceased known to have a friend or relative commit suicide?	☐	☐	☐
8. Was deceased known to have ever intentionally injured him or herself?	☐	☐	☐
9. Had deceased ever engaged in behaviors that threatened his/her own life?	☐	☐	☐

III. NARRATIVE

BRIEFLY DESCRIBE ANY ADDITIONAL CIRCUMSTANCES OR INFORMATION NOT INCLUDED IN PART 1. PROVIDER REPORT